UROLOGY ASSOCIATES OF SOUTH BEND, P.C.
PATIENT INFORMATION

DATE: _____

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____ - _____ - _____ Age _____ SS # _____ - _____ - _____

Gender ☐ M ☐ F Marital Status ☐ M ☐ S ☐ W ☐ D

Emergency Contatct _____ Relationship _____ Phone ( ) _____

Family Physician _____ Phone ( ) _____ City/State _____

Referring Physician _____ Phone ( ) _____ City/State _____

☐ Student ☐ Retired ☐ Unemployed ☐ Employed ☐ Disabled

Employer _____ Work Phone ( ) _____

Address _____City/State _____ Zip _____

MEDICAL INFORMATION RELEASE

I hereby authorize Urology Associates of South Bend, P.C. to release any medical or appointment information to the following persons
(eg: spouse, mother/father, children, friends, etc.)

Name	Relationship	Phone #

INSURANCE INFORMATION

Primary Insurance Co. Name _____ Policyholder Name _____

ID # _____ Group # _____ Employer Insurance Plan? ☐ Y ☐ N

Secondary Insurance Co. Name _____ Policyholder Name _____

ID # _____ Group # _____ Employer Insurance Plan? ☐ Y ☐ N

WORKER'S COMPENSATION: Written authorization from employer is required.

POLICYHOLDER / PARENT / SPOUSE INFORMATION (If Not Patient)

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Relationship to Patient _____

Gender ☐ M ☐ F Date of Birth _____ - _____ - _____ SS # _____ - _____ - _____

Insured's Employer _____ Work Phone ( ) _____

Street Address _____ City _____ State _____ Zip _____

UROLOGY ASSOCIATES OF SOUTH BEND, P.C.
PATIENT INFORMATION

MEDICARE AUTHORIZATON

I request that payment of authorized Medicare benefits be made on my behalf to Allied Physicians of Michiana for any services provided. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the standard HCFA 1500 insurance form, or elsewhere on other approved claim forms or electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. The physicians of Allied Physicians of Michiana accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare center.

Signature _____ **Date** _____

MEDICARE SUPPLEMENT / MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the Allied Physicians of Michiana for any services furnished me by the physician/supplier. I authorize any holder of medical information needed to determine these benefits or benefits for services provided.

Signature _____ **Date** _____

INSURANCE / SELF PAY AUTHORIZATION

(ALL PATIENTS SIGN)

I HEREBY AUTHORIZE MY PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS OR THIRD PARTY PAYORS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) OR ALLIED PHYSICIANS OF MICHIANA ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. IN THE EVENT I DEFAULT ON PAYMENT AND THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR OTHER AGENCY FOR COLLECTION, I AGREE TO PAY REASONABLE ATTORNEY FEES AND/OR COLLECTION AGENCY FEES, MEDIATION FEES AND COURT COSTS INCURRED IN THE COLLECTION OF MY ACCOUNT BALANCE AS ALLOWED BY LAW.

Signature _____ **Date** _____